CHAPTER I: OVERVIEW OF HOME HEALTH PROSPECTIVE PAYMENT SYSTEM

OBJECTIVE

This chapter provides participants with an overview of the home heath prospective payment system. It also introduces terminology and concepts that will facilitate understanding of the detailed discussion in later chapters.

OVERVIEW

HH PPS

- **Effective Services on/after 10/1/2000**
- **All HH Services Previously Covered/Paid on Cost Basis**
- **Replaces IPS**

Effective for claims with dates of service on or after October 1, 2000, Medicare implements the home health prospective payment system (HH PPS). HH PPS applies all home health agency services previously covered and paid on a reasonable cost basis, including medical supplies.

HH PPS will pay home health agencies a predetermined base payment. The payment will be adjusted for the health condition and care needs of the beneficiary. The payment will also be adjusted for the geographic differences in wages across the country.

Episode of Care Payment

- **60-day Period**
- **Adjusted for Health Condition and Care Needs**
- **Adjusted for Wage Variances**

HH PPS will provide HHAs with payments for 60-day "episodes of care" for each beneficiary. If a beneficiary is still eligible for care after the end of an episode, a second episode can begin. The payments will be adjusted for health condition, care needs and geographic variances in wages. There are no limits to the number of episodes a beneficiary eligible for the home health benefit can receive.

Payment under HH PPS will result in the discontinuation of the interim payment system (IPS)Created by the Balanced Budget Act of 19997 (BBA) and amended by the Omnibus Consolidated and Emergency Supplemental Appropriations Act of 1999 (OCESAA).

BACKGROUND

BBA

- **Initial implementation Date of 10/1/99**
- **Allowed for Transitional Period**
- **Provided General Requirements**

BBA

BBA requires HCFA to develop a prospective payment system for home health and implement the system beginning October 1, 1999. All services covered and paid on a reasonable cost basis at the time of enactment of the provision, including medical supplies, will be required to be paid on a prospective basis.

In implementing the system, a transition period of not more than four years could be provided. In the transition period a portion of the payments could be based on agency-specific costs, but only if aggregate payments are not greater than they would be if a transition period did not occur.

BBA required the definition of an appropriate unit of service and a number of visits provided within that unit, potential changes in the mix of services provided within that unit and their cost, and a general system design that provides for continued access to quality services.

General Requirements

- **Current Audited Cost Report Data**
- **Budget Neutral**

BBA does not specifically identify the prospective payment system for HHAs, but establishes some general requirements.

- A standard prospective payment amount will initially be based on the most current audited cost report data available to HCFA.

- Initially, payment amounts under HH PPS must be computed in such a way that total payments will equal the amount that would have been paid had the system not been in place. Payment amounts are to be computed reflecting the 15 percent reduction in cost limits and per-beneficiary limits in effect Sept. 30, 1999.

General Requirements (Cont.)

- **Standardized for Case Mix and Wage Levels**
- **Home Health Market Basket**
- **Outlier Payments**
- **Prorated for Transfer Between HHAs**
- **Elimination of PIP**

- Payments are to be standardized in a manner that eliminates the effect of variations in relative case mix and wage levels among different home health agencies. Actual payments for services under the prospective system will be similarly adjusted.

- Beginning in FY 2001, standard prospective payment amounts will be adjusted by the home health market basket.

- The prospective system can provide for outlier payments. However, these payments cannot exceed 5 percent of total payments under the system. If payments will be made for outlier services, the standard prospective payments must be reduced to achieve budget neutrality.

- If a beneficiary transfers or receives services from another HHA within the period covered by the PPS amount, then the payment must be prorated between agencies.

- Periodic interim payments will be eliminated with the enactment of the prospective payment system.

OCESSA

- **Effective for Services on or After 10/1/2000**
- **Budget Neutral**
- **Update at Market Basket Minus 1.1**

OCESAA

OCESAA modified the following provisions for HH PPS as established by BBA:

- OCESAA clarified that HH PPS would be effective for portions of cost reporting periods occurring on or after October 1, 2000.

- OCESAA required that the standard prospective payment limitation amounts be budget neutral to what would be expended under the interim payment system with the per-visit and per-beneficiary limits reduced by 15 percent at the inception of HH PPS.

- For fiscal years 2002 and 2003, the standard prospective payment amounts will be increased by the home health market basket minus 1.1 percentage point. Subsequent fiscal year rates

will be increased by the home health market basket.

BBRA-99

- **Delay in 15% Reductions**
- **Consolidated Billing**
- **Oasis Payment**

BBRA

The Balanced Budget Refinement Act of 1999 (BBRA) contained the following major provisions that affected the development and implementation of HH PPS:

- Under the HH PPS total Medicare payments to home health agencies were to be adjusted for budget neutrality. BBRA delays the 15% reduction in home health payments until 12 months after implementation of the PPS.

- Durable medical equipment, including oxygen and oxygen supplies, will be excluded from the consolidated billing requirements of HH PPS.

- BBRA provides payments to home health agencies of $10 for each beneficiary served during a cost reporting period beginning in FY 2000. By April 1, 2000, HCFA was required to pay an estimated 50% of the aggregate annual amount. The final payment will be made with the submission of the cost report for the provider period beginning in FY 2000.

Proposed Rule

- **Published 10/28/99**
- **60-Day Public Comment Period**
- **Final Rule by July 2000**

Proposed Rule

HCFA published a proposed rule in the *Federal Register* on October 28, 1999. The proposed rule set forth requirements for a new prospective payment system for home health agencies as required by BBA and amended by OCESSA and BBRA. HCFA received approximately 380 timely comments on the HH PPS proposed rule. HCFA considered all comments received during the 60-day public comment period. Responses to public comments and corresponding policy modifications are included in the final rule. The final rule was published on July 3, 2000.

FINAL RULE

The final rule establishes requirements for the new prospective payment system for home health agencies as required by section 4603 of the BBRA, as amended by section 5101 of the OCESSA and by sections 302, 305, and 306 of the BBRA. The requirements include the implementation of a prospective payment system for home health agencies, consolidated billing requirements, and a number of other related changes. The prospective payment system described in the final rule replaces the retrospective reasonable-cost-based system currently used by Medicare for the payment of home health services under Part A and Part B. The regulations are effective October 1, 2000.

Unit of Payment

- **60-Day Episode**
- **Coordinates with OASIS**

Unit of Payment – 60 Day Episode

Under HH PPS the 60-day episode is the basic unit of payment. Evidence from the Phase II per-episode HH PPS demonstration illustrated that the length of a 60-day episode captured a majority of the patients. In addition, the 60-day episode coordinates with the 60-day physician re-certification of the plan of care and with the 60-day reassessment of the patient using the Outcomes and Assessment Information Set (OASIS). As result, physicians will be more likely to become involved in the plan of care.

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Split Payment Approach

- **Initial Episode 60/40 Split**
- **Subsequent Episodes 50/50 Split**

Split Percentage Payment Approach

In order to maintain a consistent cash flow to agencies accustomed to billing on 30-day cycles or receiving periodic interim payments, HH PPS will incorporate a split percentage billing for each 60-day episode. Under this system, for an initial episode an agency would receive an initial payment of 60% of the case-mix and wage-adjusted 60-day episode rate as soon as it notifies the fiscal intermediary of an admission. A final 40% payment would be made at the close of the 60-day episode.

For subsequent episodes the initial percentage payment will be 50% and residual final payment will be 50%.

Request for Anticipated Payment

Documentation

Request for Anticipated Payment

The request for anticipated payment (RAP) for the initial percentage payment is not a claim and is not subject to the requirement that the physician sign the plan of care before the HHA bills for the initial percentage payment. However, the RAP must be based on the following supporting documentation:

- A physician's verbal order that is recorded in the plan of care that includes a description of the patient's condition and the services that should be provided, and

- an attestation relating to the physician's orders (and the date received) signed and dated by the registered nurse or qualified therapist responsible for furnishing or supervising the ordered service in the plan of care. The attestation must be copied in the plan of care, which should be immediately submitted to the physician or

- A referral prescribing detailed orders for the services to be rendered that is signed and dated by a physician.

A RAP is not equivalent to a claim and is not subject to either the payment floor or interest payments.

Partial Episode Payment

Accounts for Key Events in Patient Care

- **Beneficiary Elected Transfer**
- **Discharge and Return to Same HHA**

Partial Episode Payment Adjustment

The partial episode payment adjustment (PEP Adjustment) provides a simplified approach to the episode definition and accounts for key events in a patient's care defined as the following:

- A beneficiary elected transfer
- A discharge and return to the same HHA

A Beneficiary Elected Transfer

Beneficiary Elected Transfer

- **Initial Episode Closed with PEP**
- **New Episode at Second HHA**

Common Ownership

In cases where the beneficiary elected transfer to another HHA, the initial episode payment will be closed out with a PEP adjustment and the 60-day episode clock will be restarted. However, the PEP adjustment will not apply if the transfer is between organizations of common ownership (Note: The final rule includes an exception to the common ownership rule when a beneficiary has moved to a different state.)

The PEP adjustment is based on the span of days including the start-of-care date/first billable service date through and including the last billable service date under the original plan of care before the discharge or transfer. The PEP adjustment is calculated by using the span of days (first billable service date through and including the last billable service date) under the original plan of care as a proportion of 60. The proportion is multiplied by the original case-mix and wage-adjusted 60-day episode payment.

Discharge and Return to Same HHA

Discharge and Return to Same HHA

- **Initial Episode Closed with PEP**
- **New Episode for Re-Admission**
- **No Change in Condition**

In cases where the beneficiary is discharged and returns to the same HHA, a new 60-day episode will be started for purposes of payment, OASIS assessment, and physician certification of the new plan of care. When a new 60-day episode begins, the original 60-day episode payment is proportionally adjusted to reflect the length of time the beneficiary remained under the agency's care before the discharge or transfer occurred. The proportional payment is the PEP adjustment.

The discharge and return to the same HHA during the 60-day episode period is only recognized when a beneficiary reached the treatment goals in the original plan of care. The original plan of care must be terminated with no anticipated need for additional home health services for the balance of the 60-day period.

The discharge cannot be a result of a significant change in condition. The discharge must be a termination of the complete course of treatment in the original plan of care. PEP adjustments cannot be used in attempt to circumvent the more conservative payment made under the significant change in condition payment adjustment.

Significant Change in Condition Adjustment

Significant Change in Condition

- **Multiple Part Calculation**
- **Proportional Payments for Periods Before/After SCIC**

The significant change in condition payment adjustment (SCIC adjustment) is the proportional payment adjustment reflecting the time both before and after the patient experienced a significant change in condition during the 60-day episode. The SCIC adjustment occurs when a beneficiary experiences a significant change in condition during a 60-day episode that was not envisioned in the original plan of care. In order to receive a new case-mix assignment for purposes of SCIC payment during the 60-day episode, the HHA must complete an OASIS assessment and obtain the necessary physician

change orders reflecting the significant change in treatment approach in the patient's plan of care.

The SCIC adjustment is calculated in multiple parts.

- The first part of the SCIC adjustment reflects the adjustment to the level of payment **before** the significant change in the patient's condition during the 60-day episode.

- The first part of the SCIC adjustment uses the span of days of the first billable service date through the last billable service date before the intervening event of the patient's significant change in condition that warrants a new case-mix assignment for payment. The first part of the SCIC adjustment is determined by taking the span of days before the patient's significant change in condition as a proportion of 60 multiplied by the original episode payment amount.

- The second part of the SCIC adjustment reflects the adjustment to the level of payment **after** the significant change in the patient's condition occurs during the 60-day episode.

- The second part of the SCIC adjustment reflects the time the patient is under the care of the HHA after the patient experienced the significant change in condition during the 60-day episode that warranted the new case-mix assignment for payment purposes. The second part of the SCIC adjustment is a proportional payment adjustment reflecting the time the patient will be under the care of the HHA after the significant change in condition and continuing until the end of the 60-day episode.

- Once the HHA completes the OASIS, obtains the necessary physician change orders reflecting the need for a new course of treatment in the plan of care, and assigns a new case-mix level for payment, the second part of the SCIC adjustment begins.

- The second part of the SCIC adjustment is determined by taking the span of days (first billable service date through the last billable service date) after the patient experiences the significant change in condition through the balance of the 60-day episode as a proportion of 60 multiplied by the new episode payment level resulting from the significant change.

- The initial percentage payment provided at the start of the 60-day episode will be adjusted at the end of the episode to reflect the first and second parts of the SCIC adjustment (or any applicable medical review or low-utilization payment adjustment (LUPA)).

Any number of significant changes in condition can occur in a 60-day period though multiple changes should prove rare.

Low Utilization Payments Adjustments

- **Four or Fewer Visits**
- **Per-Visit Methodology**

Low-Utilization Payment Adjustment

Low-utilization payment adjustments (LUPAs) are based on the standardized average per-visit amount. Episodes with four or fewer visits will be paid the per-visit amount times the number of visits actually provided during the episode. "Savings" from reduced episode payments would be redistributed to all episodes.

Case-Mix

- **Developed by Abt**
- **Selected Oasis Items**
- **Therapy Element**

Case-Mix Methodology

The case-mix system developed under a research contract with Abt Associates, Inc., of Cambridge, Massachusetts, uses selected data elements from the OASIS assessment instrument and an additional data element measuring receipt of therapy services of at least 8 hours (the 8-hour threshold has been defined as 10 visits for purposes of case-mix adjustment of PPS reimbursements). The data elements are organized into three dimensions:

- To capture clinical severity factors,
- Functional severity factors, and

- Service utilization factors influencing case-mix.

Case-Mix

- **Clinical Severity**
- **Functional Severity**
- **Service Utilization**
- **80 Possible Combinations**

The process of selecting data elements for each dimension was described in the final rule. In the clinical and functional dimensions, each data element is assigned a score value derived from multiple regression analysis of the Abt research data. The score value measures the impact of the data element on total resource use. Scores are also assigned to data elements in the service's utilization dimension.

To find a patient's case-mix group, the case-mix grouper:

- Sums the patient's scores within each of the three dimensions.
- The resulting sum is used to assign the patient to a severity level on each dimension.

There are four clinical severity levels, five functional severity levels, and four services utilization severity levels.

As a result, there are 80 (4x5x4) possible combinations of severity levels across the three dimensions. Each combination defines one of the 80 groups in the case-mix system. For example, a patient with high clinical severity, moderate functional severity, and low services utilization severity is placed in the same group with all other patients whose summed scores place them in the same set of severity levels for the three dimensions.

National 60-Day episode Payment

Average Prospective Payment Amount $2,416.01, adjusted for:

- **Wage index**
- **Case-mix**
- **Budget Neutrality**
- **Outliers**

2001 Standard Prospective Payment Rate $2,115.30

National 60-Day Episode Payment

The standard average prospective payment amount for the 60-day episode equals the non-standardized average prospective payment amount of $2,416.01 for a 60-day episode divided by a standardization factor of .96184. The standardization factor is applied to eliminate variations in wage index and case-mix amounts. Once the payment rates have been standardized, that amount is multiplied by the budget-neutrality adjustment factor of .88423. The standardized budget-neutral amount is divided by 1.05 to account for outlier payments that are limited to 5% of total estimated outlays under HH PPS.

The result of the above calculations is a final standardized and budget neutral prospective payment amount per 60-day episode of $2,115.30 for FY 2001.

Wage Index

- **Hospital Wage index**
- **Pre-Reclassification**
- **Pre-Floor**
- **Labor Portion 77.668%**

Wage Index

Under HH PPS, the labor portion of the 60-day episode payment will be adjusted by the appropriate wage index for the geographic area in which the beneficiary received home health services. The hospital wage index in effect for the federal fiscal year will be used to determine payments for home health services. The wage index values, pre-floor and pre-reclassification, will be published in the *Federal Register*.

Based on an analysis of the components of the HH market basket, HCFA has determined that 77.668% of the standardized prospective payment rate represents labor costs.

Outlier Payments

- **Fixed Dollar Loss Amount**
- **80 Percent Recovery**

Outlier Payments

Outlier payments are payments made in addition to the 60-day episode payments for episodes that incur unusually large costs.

- Outlier payments will be made for episodes whose estimated cost exceeds a threshold amount for each case-mix group.

- The outlier threshold for each case-mix group, PEP adjustment or total SCIC adjustment will be the episode payment amount, PEP adjustment, or total SCIC adjustment for that group plus a fixed dollar loss amount (113% or the standard episode amount) that is the same for all case-mix groups.

- The outlier payment will be 80% of the amount of estimated costs beyond the threshold.

- Costs will be estimated for each episode by applying standard per-visit amounts to the number of visits by discipline reported on claims.

The fixed dollar loss amount and the loss-sharing proportion are chosen so that total outlier payments are estimated to be no more than 5% of estimated total payments. There is no need for a long-stay outlier payment since there is no limitation on the number of continuous episode payments in a fiscal year for a beneficiary.

Consolidated Billing/Bundling

Under the consolidated billing requirement, HHAs are required to submit all Medicare claims for the home health services included in section 1861(m) of the Social Security Act, while the beneficiary is under the home health plan of care established by a physician and is eligible for the home health benefit.

Section 305 of BBRA-99 amended the consolidated billing language governing home health PPS by eliminating DME covered as a home health service from the consolidated billing requirements.

Specific Provisions

- Requires payment for all items and services to be made to a HHA.

- Requires, in the case of home health services (including medical supplies) provided for or furnished to an individual who (at the time the item or service is furnished) is under the plan of care of a home health agency, payment shall be made to the agency (without regard to whether or not the item or service was furnished by the agency, by others under arrangement with them made by the agency, or when any other contracting or consulting arrangement, or otherwise).

- Requires separate payment for DME items and services provided under the home health benefit, which are under the DME fee schedule.

- In addition to the prospective payment amount for home health services, a separate payment amount will be made for DME currently covered as a home health service under the PPS.

Types of Services That Are Subject to the Provision

The home health services included in consolidated billing are:

- Part-time or intermittent skilled nursing care
- Part-time or intermittent home health aide services
- Physical therapy
- Speech-language pathology
- Occupational therapy, medical social services
- Routine and nonroutine medical supplies
- A covered osteoporosis drug
- Medical services provided by an intern or resident-in-training of the hospital, under an approved teaching program of the hospital in the case of an HHA that is affiliated or under common control with a hospital
- Services at hospitals, SNFs, or rehabilitation centers when they involve equipment too cumbersome to bring to the home

Effects of This Provision

HHAs will no longer be able to "unbundle" services to an outside supplier that can then submit a separate bill directly to the Part B carrier. Instead, the HHA itself will have to furnish the home health services (except DME) either directly or under an arrangement with an outside supplier in which the HHA itself, rather than the supplier, bills Medicare. With the exception of DME, the outside supplier must look to the HHA rather than to Medicare Part B for payment. Beneficiaries receiving DME prior to establishment of a home health plan of care can continue the relationship with that same DME supplier. The consolidated billing requirement eliminates the potential for duplicative billings for the same services to the RHHI by the HHA and to the Part B carrier by an outside supplier.

The effective date for consolidated billing is October 1, 2000.

CHAPTER I APPENDIX – SUMMARY OF POLICY CHANGES FROM HHPPS PROPOSED RULE PUBLISHED ON OCTOBER 28, 1999 COMPARED TO FINAL RULE